Patient Insurance Verification and Prior Authorization Request Form

❏ New patient   ❏ Re-verification   ❏ Additional applications   ❏ New insurance

Sales representative name _____

Patient and Insurance Information

Patient name _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Is the patient currently residing in a skilled nursing facility? ❏ Yes ❏ No   If yes, is the patient covered under a Part A stay? ❏ Yes ❏ No

If patient is currently under a surgical global period, please indicate date and procedure completed

Procedure (CPT) code(s) _____ Date of procedure _____

Primary insurance _____ Policy # _____ Payer phone _____

Secondary insurance _____ Policy # _____ Payer phone _____

Tertiary insurance _____ Policy # _____ Payer phone _____

Workers comp claim # _____ Adjuster name _____ Adjuster phone _____

Physician and Facility Information

Physician name _____ Physician specialty _____

NPI # _____ Medicare (PTAN) provider # _____

Tax ID _____ Medicaid provider # _____

Office contact _____ Phone _____ Fax _____

Treating facility place of service (POS)
❏ Hospital-based outpatient wound department (HOPD – POS 22)   ❏ Ambulatory surgery center (ASC – POS 24)
❏ Physician office (POS 11)
❏ Other (please specify, e.g. critical access hospital or POS 19 off-campus) _____

Facility name _____

Facility address _____ City _____ State _____ Zip _____

NPI # _____ Tax ID _____

Medicare contractor (MAC) and Provider ID (PTAN) for claims processing _____

Product and Treatment Information

Product: ❏ (Q4253) Zenith   ❏ (Q4262) Impax   ❏ (Q4268) SurGraft FT   ❏ (Q4276) Orion   ❏ (Q4173) PalinGen   ❏ (A2001) InnovaMatrix

Application codes: 15271 – 15274 for wounds on the trunks, arms, and/or legs
              15275 – 15278 for wounds on the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits

Anticipated treatment start date _____ Number of applications _____ Frequency _____

Total surface area of all wounds _____

Diabetic foot ulcer	**Venous leg ulcer**	**Pressure ulcer or chronic wound**	**Other**
E code _____	I code _____	L code _____	_____
L code _____	L code _____		

I certify I have obtained a valid authorization under applicable law from the patient listed on this form (a) permitting me to release the patient's protected health information to Legacy Medical and its contractors to research insurance coverage regarding Legacy Medical products, and to provide me with reimbursement assistance services regarding such products; and (b) authorizing the payer to disclose PHI to Legacy Medical and its contractors for the purposes of determining benefit coverage.

Provider signature _____ Date _____

Please send form along with a copy of the front and back of patient's insurance card to sunderwood@prodatamgmt.com or fax to (866) 205-0732.

If further assistance is needed, please contact IVR Support Team at (919) 249-7293 for additional support.

LEGACY MEDICAL CONSULTANTS